DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03-27**

2. STATE: **New York**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **April 1, 2003**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Section 447.204

7. FEDERAL BUDGET IMPACT:
a. FFY **4/1/03 – 9/30/03 ($ 20,725,000)**
b. FFY **10/1/03 – 9/30/04 ($ 41,450,000)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 1(b), 1(c)(i), 1(d), 2(b), 2(b)(i), 2(c)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 1(b), 1(c)(i), 1(d), 2(b), 2(b)(i), 2(c)

10. SUBJECT OF AMENDMENT:
Non-Institutional Services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Kathryn Kuhmerker

13. TYPED NAME: **Kathryn Kuhmerker**

14. TITLE: **Deputy Commissioner**
Department of Health

15. DATE SUBMITTED:
June 27, 2003

16. RETURN TO:
New York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: [illegible]

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: [illegible] 01 20[illegible]

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Sue Kelly

22. TITLE: [illegible] Administrator
Division of Medicaid and State Operations

23. REMARKS:

New York (03-27)
approved: 03/03/04
effective: 04/01/03

FORM HCFA-179 (07-92)

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(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2005 for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or Statewide ceiling of $150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of $67.50 per visit. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2005 the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, shall be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of $95 per visit. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2005 the capital costs per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

All rates are subject to approval by the Division of the Budget. For emergency room services only, a retrospective adjustment may be made if it is determined that patients requiring general clinical services are provided such services in the emergency room for the sole purpose of maximizing reimbursement.

Designated Preferred Primary Care Provider for Hospital-Based Outpatient Clinics and Hospital-Based Specialty Clinic Services

Hospital-Based clinics seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health. Providers seeking reimbursement for certain outpatient specialty clinic services are required to document in writing and through site inspection or records review that they are in fact organized as and providing specialty services.

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payments received by a provider from beneficiaries and carriers or intermediaries for providing comparable services under Medicare.

Trend Factors

Notwithstanding any inconsistent provision of this state plan, effective April 1, 2000, in those instances when trend factors are used in determining rates of payment for hospital outpatient services, diagnostic and treatment centers unless otherwise subject to the rate freeze set forth herein, certified home health agencies, and personal care services, the commissioner of health shall apply trend factors in accordance with the following:

(1) For rate periods on and after April first, two thousand, the commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation except that such trend factors shall not be applied to services whose rate of payment are established by the commissioners of the department of mental hygiene. The factors shall be applied to the appropriate portion of reimbursable costs.
(2) In developing trend factors for such rates of payment, the commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget outlook after June first of the rate year prior to the year for which rates are being developed.
(3) After the final U.S. Consumer Price [index] Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the Commissioner shall reconcile such final CPI to the projection used in number two of this section and any difference will be included in the prospective trend factor for the current year.

Nothing in this section is intended to produce a change in any existing provision of law establishing maximum reimbursement rates.

Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law; Including Federally Qualified Health Centers

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995 through March 31, 1999, and on or after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31 2003, and on and after April 1, 2003 through March 31, 2005, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this

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The rates include a capital cost component. For fiscal year ending March 31, 1994, such rates are trended and extended to September 30, 1994. Commencing October 1, 1994 and thereafter, such rates shall be calculated as above for fiscal years beginning October 1, and ending September 30 except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2003] 2005. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Payment rates for renal dialysis services of $150.00 per procedure are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. A single price per visit for day health care services rendered to patients with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses is determined based on reasonable projections of necessary costs and utilization and trended to later rate years. Price components may be adjusted for service capacity, urban or rural location and regional differences. Rates are subject to approval of the Division of the Budget.

Additional Funding for Diagnostic and Treatment Centers for the period October 1, 1999 through December 31, 1999

Rates for diagnostic and treatment centers for the period October 1, 1999 through December 31, 1999 shall include, in the aggregate, the sum of fourteen million dollars ($14,000,000) which shall be added to rates of payment based on an apportionment of such amount using a ratio of each individual provider's estimated Medicaid expenditures to total estimated Medicaid expenditures for diagnostic and treatment centers, as determined by the Commissioner, for the October 1, 1999 through September 30, 2000 rate period.

Additional Funding for Diagnostic and Treatment Centers Providing Services to Persons With Developmental Disabilities

For the period July 1, 2000, through March 31, 2001 and annual state fiscal periods thereafter, fee-for-service rates of payment for medical assistance services provided to patients eligible for federal financial participation under title XIX of the federal social security act by diagnostic and treatment centers licensed under article 28 of the public health law that provide services to individuals with developmental disabilities as their principal mission, shall be increased by annual amounts of two million two hundred eighty thousand dollars ($2,280,000) in the aggregate. Each such diagnostic and treatment center shall receive a proportionate share of these funds based upon the ratio of its medical assistance units of service to the total medical assistance units of service of all such facilities during the base year. The base year shall be the calendar year immediately proceeding each annual period. There shall be no reconciliation of the amount added to rates of payment pursuant to this section to reflect the actual number of Medicaid units of service for affected providers for the period July 1, 2000 to March 31, 2001 and annual state fiscal periods thereafter.

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Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law

Services for AIDS and HIV positive patients

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

Freestanding Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law As Freestanding Diagnostic and Treatment Centers

Services for AIDS and HIV positive patients

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2003] 2005.

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Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law

Services for medically supervised chemical dependence treatment and medically supervised withdrawal services

For dates of service beginning on July 1, 2002, for those facilities certified under Article 28 of the State Public Health Law, the Department of Health promulgates prospective, all-inclusive rates based upon reported historical costs. Allowable operating costs per visit are held to legislatively established ceiling limitations. Reported historical operating costs on a per visit basis, which are below or limited by ceilings, are deemed reimbursable and trended forward to the current rate period to adjust for inflation. Non-operating costs (such as capital costs) are not subject to the legislatively established ceiling and are added to the product of reimbursable operating costs times the roll factor (two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, [2003] 2005, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of $67.50 per visit.

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Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

**reestanding Diagnostic and Treatment
enters**

Facilities Certified Under Article 28 of the Public Health Law as Freestanding Diagnostic and Treatment Centers

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2003] 2005.

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